ISPN Perspectives in PSYCHIATRIC CARE

Perspectives in Psychiatric Care ISSN 0031-5990

Who Cares If It Is a Hate Crime? Lesbian, Gay, Bisexual, and Transgender Hate Crimes—Mental Health Implications and Interventions

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Search terms:
Hate crime, LGBT, mental health, survivor, victim

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Conflict of Interest Statement
The authors report no actual or potential conflicts of interest.

First Received December 31, 2011; Final Revision received June 29, 2012; Accepted for publication July 23, 2012.

doi: 10.1111/j.1744-6163.2012.00354.x

PURPOSE: The purpose of this paper was to discuss lesbian, gay, bisexual, or transgender-targeted hate crimes and their mental health consequences for the victim and community.
CONCLUSIONS: Hate crimes are typically more violent than nonhate-motivated crimes and have more deleterious mental health consequences.
PRACTICE IMPLICATIONS: Thorough assessment coupled with an understanding of the social milieu and the meaning of the experience to the survivor can help the psychiatric nurse partner with the client to select the most appropriate treatment.

So who cares if it is a hate crime? Certainly psychiatric–mental health nurses and other professionals need to care if the individual for whom they are providing services has been the victim of a lesbian, gay, bisexual, or transgender (LGBT) hate crime because it impacts nursing interventions and client outcomes. LGBT hate crimes can cause both physical and emotional problems for the victims that may bring them to the attention of healthcare providers. Understanding more about LGBT hate crimes and the impact on the victims is important to be an effective provider of mental health services. The prevalence of LGBT people in the population is substantial, yet this is a group that has not been addressed by psychiatric nurses, both in victimization research and, until recently, in public policy decisions (Eliason, Dibble, & DeJoseph, 2010; Lim & Levitt, 2011). The purpose of this paper is to describe LGBT-targeted hate crime victimization, the unique facets of these crimes, the mental health consequences for the individual and the LGBT community, and to subsequently discuss interventions the psychiatric nurse can employ to assist these victims. Due to the relative lack of research on LGBT hate crime victimization, studies from as early as the 1990s are included in the literature review for this paper to provide background for the problem and discussion of nursing's role.

Psychiatric nurses are often in a position to help survivors of LGBT hate crimes (Sun, 2006), either in consultation-liaison nursing roles or by providing direct counseling, social support, and/or empowerment services for LGBT survivors. As with any other culture or minority group, it is imperative to understand the culture. While it is convenient to consider the LGBT community as a whole, it is important to remember that there are specific subcultures and differences among the various groups comprising the LGBT community. As the Institute of Medicine (IOM) reports, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* notes that the factors that tie these subgroups together is their status as marginalized groups of "others," individuals who do not share the gender norms of heterosexuality of the greater population. The stigma, prejudice, discrimination, and violence LGBT people experience often result in health disparities and may be further complicated by other types of inequalities related to ethnicity, race, or socioeconomic status (IOM, Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues, and Research Gaps and Opportunities, & Board on the Health of Select Populations, 2011, p. 13).

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Prevalence of LGBT People

There is currently no national or census-like measure of the number of LGBT people in the United States.[1] Prevalence estimates must be used to approximate the number of LGBT people in the population. There is substantial inconsistency in estimates of the prevalence of hate crime victimization, largely due to discrepancy in how hate crimes are defined, measured, and the source of information. Sell, Wells, and Wypij (1995) found that in a sample of 4,000, 21% of males and 18% of females reported either homosexual behavior or attraction since age 15. Gates (2011) reported figures for the LGBT population, but noted that these figures can vary greatly depending upon how the population members are defined and how these data are collected. Approximately 3.5% of American adults are lesbian, gay, or bisexual, while another 0.3% of adults are transgender. This amounts to 9 million LGBT American adults but does not include the number of youth in these percentages. An estimated 19 million people report being involved in any sexual behaviors with members of the same sex at some point in their lifetime while 25.6 million American adults reported having experienced some degree of sexual attraction for members of the same sex (Gates, 2011).

Heterosexism

Heterosexism is an "ideological system that denies, denigrates, and stigmatizes any non-heterosexual form of behavior, identity, relationship, or community" (Herek, 1990, p. 316). Heterosexism refers to an underlying belief that heterosexuality is the only normal, and acceptable form of sexual expression (Williamson, 2000, p. 97). Heterosexism leads to the marginalization of LGBT people by perpetuating the view that nonheterosexual feelings, behaviors, and relationships are deviant or inherently flawed (Garnets & D'Augelli, 1994), and manifests itself at cultural, psychological, and institutional levels (Herek, 1990). Unfortunately, sometimes these beliefs become internalized by the LGBT individual as internalized homophobia.

LGBT Hate Crime Victimization

The National Coalition of Antiviolence Programs (NCAVP) measures the prevalence of hate crimes, including homicide, targeting LGBT individuals. The NCAVP recorded 2,503 victims of LGBT-targeted hate crimes in 2010 which was 322 (7.8%) more victims than in 2009 (NCAVP, 2011). Sexual orientation bias was the motivator for 19% of all hate crimes in 2010 (Federal Bureau of Investigation, 2011). Only race was a more prevalent bias motivator than sexual orientation. Of LGBT persons, transgender people suffer the most victimization.

The NCAVP (2011) report found that transgendered persons were proportionally twice as likely as gay, lesbian, or bisexual persons to be victims of assault or discrimination. Transgendered people also were proportionally more likely to be seriously injured than gay, lesbian, or bisexual persons, but were least likely to receive medical care (NCAVP, 2011).

Hate Crimes Prevention Laws

In 2009, the Matthew Shepard and James Byrd, Jr., Hate Crimes Prevention Act 18 U.S.C. § 249 was ratified. This act was the first federal hate crimes law to provide protection for the LGBT population, and in conjunction with H.R. 335 (Violent Crime Control and Law Enforcement Act, H. R. 3355 C.F.R., 1994) mandates longer sentences for individuals found guilty of committing hate crimes under federal jurisdiction. The Shepard/Byrd Act criminalizes violent acts resulting in bodily injury or attempted bodily injury, through the use of fire, firearms, explosive and incendiary devices, or other dangerous weapons. The statute does not criminalize either threats of violence or damage to property. Because it is a federal act, hate crimes only fall within the purview of the federal courts if the crimes were committed across state lines, the actions interfere with interstate commerce in some way, or if state-level prosecutors refer the cases for federal prosecution (state laws vary considerably). Although 45 states have state-level hate crime statutes (Arkansas, Georgia, Indiana, South Carolina, and Wyoming do not) only 31 states include crimes based on sexual orientation in their hate crime statutes and just 12 states include gender identity as a basis for hate crimes (Anti-Defamation League, 2011; Human Rights Campaign, 2011).

Characteristics of LGBT Hate Crimes

It is often asked: "Who cares if it's a hate crime?" A lack of understanding of the differences between hate crimes and other crimes against persons may make people wonder why hate crimes deserve special attention. There are several unique features of hate crimes that make a difference. Messner, McHugh, and Felson (2004) found that hate crimes are more likely to be unprovoked and victims nearly three times as likely to be seriously injured by the assault compared with other crimes. Studying hate crime *offenders*, McDevitt, Levin, and Bennett (2002) found that 60% of the offenders' motive was to harm someone perceived as different from themselves. Comparing 1,538 hate crimes based on race, gender, and sexual orientation in L.A. County, Dunbar (2006) found sexual orientation-motivated hate crimes to be more

[1] The census measures legally married/legal domestic partner relationships. The census does not measure LGBT individuals or LGBT couples in locations where legal recognition of same-sex marriage or domestic partnerships does not exist.

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violent than other hate crimes. Additionally, the occurrence of a hate-motivated sexual assault was predictive of a sexual orientation hate crime.

Reporting Hate Crimes to the Police

The 2010 NCAVP data showed that 50% of LGBT hate crime survivors did not report the crime to police. Of those who did report to police, 61% of victims reported indifference, abuse or being discouraged to file a report (NCAVP, 2011). Police refused to file a report on the victimization in 17% of cases (NCAVP, 2011). Additionally, police officers, those who are supposed to protect victims, were the perpetrators of these crimes in 8% of cases (Kuehnle & Sullivan, 2001; NCAVP, 2011); consequently, hate-motivated crimes are underreported to law enforcement. In a survey completed by 249 police officers, approximately 40% of police officers suggested that gays and lesbians were unlikely to be treated fairly by the justice system when reporting hate crimes (Bernstein & Kostelac, 2002). Note that 22% more victims of hate-motivated violence *decided not to* report their victimization to the police in 2010 than in 2006 (Dunbar, 2006; NCAVP, 2011). This is noteworthy, because victimization related to sexual orientation or gender identity was not included in hate crime legislation until 2009 (The Matthew Shepard and James Byrd Jr. Hate Crimes Prevention Act, 2009). Negative attitudes of police officers toward homosexuals have been supported in the literature (Walker, Archer, & Davies, 2005). Studying police officers in Texas, Lyons et al. (2005) found officers made more punitive judgments when they believed a suspect to be homosexual; transgender individuals were treated even more poorly.

The situation is even more dire for transgender victims. In a large study of transgendered persons ($N = 2{,}181$), 46% reported being uncomfortable seeking help from the police; this hesitancy to interact with law enforcement is likely due to a history of harassment (29%) and assault (6%) when interacting with police (Grant et al., 2011; NCAVP, 2010). Equally troubling, 12% of 6,450 transgender victims report harassment and being denied equal treatment by a judge or court official; 6% by an attorney; and 4% by a rape crisis center (Grant et al., 2011).

Unique Aspects of LGBT Hate Crime Victimization

There are unique facets of LGBT-targeted hate crimes. One unique issue with hate-biased crimes is their intent to foster fear and destroy the spirit of a group or community. As President Obama (2009) noted:

> we must stand against crimes that are meant not only to break bones, but to break spirits – not only to inflict harm, but to instill fear. You understand that the rights afforded every citizen under our Constitution mean nothing if we do not protect those rights – both from unjust laws and violent acts. . . . Because no one in America should ever be afraid to walk down the street holding the hands of the person they love. No one in America should be forced to look over their shoulder because of who they are (p. 1).

Another unique facet is the lack of family and community preparation of LGBT children for hate crimes against them. In religious, ethnic, and race-based hate crimes, the victimized individuals have typically been raised to cope with being targeted for their religious beliefs, ethnicity, or race. If the skills to cope with hate crimes are not directly taught, they are conveyed by the actions of the adults when a hate crime happens to a community member. The family system comes to the aid of individuals targeted for hate crimes due to race, ethnicity, or religion. And the unity of the family often includes an extended family system to assist with support. Victims of LGBT-targeted hate crime have not had family understanding and support preparing them for hate crime victimization based on their sexual orientation/gender identity. Many families may not recognize that their child is LGBT until adolescence or later because many LGBT youth may not acknowledge they are LGBT until later in young adulthood. Coming out to family is often a difficult event accompanied by much anxiety and fear in the LGBT person. Even very accepting families experience a variety of emotional reactions to their child's coming out; in other families, the announcement results in extremely negative reactions such as disowning of the LGBT person. Typically heterosexual parents would not think about or know how to prepare their child for the possible victimization, even if the parents recognized their child's sexual orientation or transgender status at an earlier age. Parents may also be reluctant to share the information about their child's coming out as LGBT with extended family or friends.

Coming out to family is often a difficult event accompanied by much anxiety and fear in the LGBT person. In some cases, this fear is well founded. Family members who have strong beliefs about LGBT behaviors being inherently wrong are sometimes the perpetrators of LGBT hate violence that targets their "loved ones" (NCAVP, 2011). Even when family members are not the perpetrators, the LGBT person may be reluctant to go to family for support because of prior negative experiences related to their sexual orientation or gender identity. Thus, there is a significant difference in family support between hate crime victimization based on race, ethnicity, or religion, versus LGBT status.

Hate Crime Settings and Perpetrators

Hate crimes are perpetrated in various settings. There were 2,503 people who reported that the most common sites are in

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private residences (32%), followed by a public area (21%), the workplace (11%), LGBT venue (8%), school (7%), public accommodations (5%), and public transportation (4%) (NCAVP, 2011, p. 34). Relationships between the LGBT person and the perpetrator were varied, with 35% of incidents between victim and strangers, 15% landlord/tenant/neighbor, 10%, employer/coworker, 8% police, 6% family, and 6% acquaintance/friend (NCAVP, 2011). With the most common site for victimization being a private residence, one might assume that interpersonal (domestic) violence was the primary source of LGBT victimization. In actuality, less than 2% of violence was perpetrated by partners/lovers (NCAVP, 2011).

Mental Health Consequences of LGBT Hate Crime Victimization

Any violent victimization can have devastating mental health consequences for the victim. Frequent psychological consequences include post-traumatic stress disorder (PTSD), increased anxiety, and/or depression. Hate crimes are one type of violent victimization and hate crimes based on sexual orientation resulted in more severe psychological consequences (Dunbar, 2006). A hate crime against an LGBT person has three major consequences. First, it destroys the myth of personal invulnerability. Second, it results in a decrease in feelings of self-worth, and third, the idea of the world as logical and reasonable is shattered (Rivers, McPherson, & Hughes, 2010) Mental health consequences of LGBT-targeted victimization include those listed above as well as psychological distress, anger, diminished self-efficacy, sleep disturbances, self-blame, victim blaming (by others), internalized homophobia (Meyer, 1995), loss of trust in others, and suicidal ideation (Herek, Gillis, & Cogan, 1999; Herek, Gillis, Cogan, & Glunt, 1997; Walker et al., 2005; Willis, 2008). Meyer's (1995) study showed that LGBT individuals experience ongoing stress related to their sexual orientation or gender identity which multiplies the impact of additional stress experienced by LGBT people compared with others who experience a similar stressful event. Violence targeting LGBT individuals is of major concern to the LGBT community, can be individually devastating, and often results in a sense of disempowerment.

The survivors may develop negative feelings about their core sexual identity, that is, internalized homophobia. Meyer and Dean (1998) described internalized homophobia as the incorporation of society's negativity toward the LGBT population into one's sense of self. Internalized homophobia can result in intrapsychic conflicts between the need for, or experiences of, same-sex love, and a counter-need to be heterosexual (Herek, 2004) to protect one's self from external negativity. Internalized homophobia has been shown to impede positive relationship development between the survivor and other members of the LGBT community (Frost & Meyer, 2009). The degree of these psychological responses will vary by the survivor's psychological strengths and weaknesses, previous experiences as survivors of violence, whether the attack had multiple perpetrators (Rose & Mechanic, 2002), and whether the incident involved sexual assault (Hazzard, Rogers, & Angert, 1993). While some members of the LGBT population may have a degree of internalized homophobia prior to experiencing hate crime victimization, the intensity of the internalized homophobia is far greater and, therefore, more incapacitating after the hate crime. Mental health consequences of hate crimes are also related to where one lives. Living in an area lacking LGBT policy and legal protection is predictive of psychiatric comorbidity (Hatzenbuehler, Keyes, & Hasin, 2009). Less than 42% of the United States has LGBT nondiscrimination protection for its citizens (National Gay and Lesbian Task Force, 2011).[2]

Sexual Assault

Hate-motivated rape can have more detrimental psychological consequences than other types of hate crime (Rose & Mechanic, 2002). Studying 306 LGBT adults, Rose and Mechanic (2002) found the highest levels of PTSD among hate crime survivors of sexual assault. Males were equally likely to have been victims of rape as females (Rose & Mechanic, 2002).

The experience of sexual assault or rape can be devastating for anyone. Male rape victims are doubly stigmatized and sometimes perceived negatively and blamed for their victimization, in particular by other males (Anderson, 2004; White & Yamawaki, 2009). Elliott, Mok, and Briere (2004) found that in a sample of 941 American males, 4% had been raped as adults and 2% of the sample had been raped as children. Studying a community sample of 88 LGBT youth, Hein (2008) reported that 53% of females and 32% of the males had been raped at least once—five times the national average for females and eight times the national average for males. One form of hate-motivated sexual assault is "corrective rape"—rape of an LGBT person by a heterosexual to "cure" them of their homosexuality (Anguita, 2011; NCAVP, 2011, p. 23).

Transgender persons are the most victimized segment of the LGBT population, (Grant et al., 2011). In a 2010 study of 6,450 transgendered persons, 35% had been physically

[2] Fifteen states and D.C. ban discrimination on sexual orientation and gender identity: California, Colorado, Connecticut, District of Columbia, Hawaii, Illinois, Iowa, Maine, Minnesota, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, and Washington. Six states ban discrimination on sexual orientation (without inclusion of gender identity): Delaware, Maryland, Massachusetts, New Hampshire, New York, and Wisconsin.

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assaulted, and 12% raped (Grant et al., 2011). Clements-Nolle, Marx, and Katz (2006) found in their sample of 523 transgender persons that rape and assault due to gender identity were predictive of suicide attempts.

LGBT people are more frequently sexually assaulted than non-LGBT people. Cramer, McNiel, Holley, Shumway, and Boccellari (2011) analyzed 641 emergency room visits for violent victimization by sexual orientation/gender identity and found that LGBT patients were 2.3 times more likely to be victims of sexual assault than heterosexuals. Not surprising, much of the violence LGBT people experience is when peers that may have intervened are absent (Hazler & Denham, 2002). Consequently, the lack of peer support is a factor that increases the likelihood of LGBT victimization (Waldo, Hesson-McInnis, & D'Augelli, 1998).

Support Systems

One's sense of safety is often dependent on the available support systems. Support from the LGBT community does not prevent victimization but is predictive of less psychological distress if one is victimized (Waldo et al., 1998). "Families of choice" are often a source of social support in the LGBT population due to estrangement from the biological family upon coming out. Enhancing the support systems of LGBT victims of hate crimes can be a valuable therapeutic intervention.

Interventions for Victims

Many of the interventions useful for survivors of hate crimes related to sexual orientation or gender identity are usual types of interventions for various mental health problems. However, the focus of and order in which these interventions are applied will be specific for each individual experiencing the hate crime. Treatment needs to include an assessment of the meaning the survivor has attributed to the hate crime, the survivor's degree of internalized homophobia, and to what degree the survivor has integrated the hate crime experience into the self-identity. Along with this, an assessment of the survivor's coping resources, including coping skills, support systems, and involvement in the LGBT community, provides important data about the survivor's need for therapy targeting coping skills (Herek & Garnets, 2007). Cognitive behavioral therapy, cognitive processing therapy, exposure therapy, and, if required, psychopharmacology, can be used in treating hate crime-engendered PTSD, as well as major depression and anxiety disorders (Cheng, 2004). The primary treatment focus for the survivor of a hate crime needs to be on the aftermath of the victimization (Herek & Garnets, 2007) beginning with a crisis intervention model when the hate crime is recent and following up with other therapeutic interventions as needed. Immediately after the hate crime has occurred, the advanced practice nurse (APRN) can consider administering a single dose of propanolol to reduce the risk of the affected individual developing PTSD (Brunet et al., 2008). Of course, some survivors of hate crimes may not reveal the attack or seek help until much later. Because the survivors have experienced an attack that is directed toward their sexual identity, their sense of vulnerability may be greater than typically experienced following other types of hate crimes. The provider should consider this increased vulnerability and potential of internalized homophobia when planning treatment with the LGBT person.

Overcoming internalized homophobia generated by the hate crime is necessary for healing (Frost & Meyer, 2009). Frost and Meyer (2009) demonstrated that depression is a major mediator of internalized homophobia's impact on relationships, but suggested that mental health professionals first need to help the survivor deal with the internalized homophobia as well as secondarily treating the depression. It is important to recognize that violence may be viewed and experienced differently.

Advanced practice psychiatric nurses need to understand the meaning of the event to the survivor rather than assuming that their own perceptions are the same as the survivor's. Meyer's (2010) sociological study of 44 hate crimes demonstrated that LGBT people of color were likely to view their own experiences as less violent than did their white counterparts whose actual experiences tended to be less physically and more verbally aggressive. Meyer (2010) noted that the support systems around the survivors of color tended to minimize the experience by comparing the event to more violent situations with more serious consequences, whereas the reverse tended to happen to the white middle class survivors. Whether the individual is completely out is important in determining interventions to be used. Some LGBT individuals may discuss a hate crime in the context of therapy but such interventions as reporting the hate crime to the police or determining appropriate referrals would be inappropriate if the person was not completely out. By understanding the survivor's perceptions, the APRN can develop interventions that best meet the survivor's needs and to empower the survivor.

Empowerment interventions may be the most effective strategies for intervening with self-doubt and homophobia. Many descriptions of empowerment can be found in the literature but one of the most cited is found in the psychology literature and is the classic definition by Rappaport (1987) who said that empowerment is "a mechanism by which people, organizations, and communities gain mastery over their affairs" (p. 122). Empowerment interventions have been a successful treatment for domestic violence survivors for many years and have been used with other groups such as Hispanic/Latina women (Amendola, 2011; Kasturirangan, 2008). Empowerment is a process that the survivors of hate

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crimes engage in rather than a specific program. Empowerment strategies help individuals create and strengthen their own identities and gain a sense of control over themselves and their own affairs (Amendola, 2011; Kasturirangan, 2008). Consciousness raising, increasing the sense of internal locus of control, sharing knowledge of resources, advocacy, or helping to develop critical awareness are actions that might be taken by the therapist to help the survivors. Each scenario will be different as each survivor is different. But the process of sharing power with the survivor is an important component of this process. Only the survivors can determine what they need to be empowered and it is the therapist's role to help them discover what those needs may be (Amendola, 2011; Kasturirangan, 2008).

Advanced practice psychiatric nurses can be essential to the facilitation and expansion of the survivor's psychosocial skills, modification of other personal resources, and their assistance with interpersonal factors will increase their sense of empowerment. One empowerment strategy would be to encourage the survivor to report at least one episode of victimization to the police. It is imperative, however, that the limits inherent in reporting be recognized and communicated to the survivor. Mitigating the risks inherent in reporting a hate crime may include taking someone with them and helping individuals have reasonable expectations of actions the police may or may not take when the evidence is absent or has been compromised due to time. However, as long as hate crimes against the LGBT population go unreported, they are likely to continue or increase in reaction to the lack of sanctions opposing the hate crimes. While the reporting process may be viewed by police as worthless due to the time lag, from the survivor's perspective taking this step even after a delay is felt as empowering as the survivor moves beyond fear and anxiety to take action.

Social support networks may also need to be empowered; the APRN should consider offering family therapy to the survivor's family of choice (Hastings & Hoover-Thompson, 2011). However, it is known that male rape survivors, in particular, tend to withdraw from their family in the aftermath of rape (Walker et al., 2005). As part of empowering the client, it is imperative to discuss whether family therapy is a viable treatment option. Determining who the client considers family is essential for empowerment and respecting the client's wishes in regard to engaging the family is critical; 6% of hate victimization is perpetrated by the family (NCAVP, 2011). A study by Rivers et al. (2010) demonstrated that those LGBT survivors who have good family support as well as a willingness to use counseling suffer from fewer trauma symptoms than survivors without these supports. Family in this context can be family of choice, that is, whoever the survivor chooses to act as family. Group therapy conducted with other victims of LGBT hate crimes may be another opportunity for the APRN to assist victims to be empowered.

Short-term, goal-focused groups which deal with specific issues could be quite helpful. For example, for the LGBT person who has just experienced a hate crime, the group might focus on the normalcy of the feelings of fearfulness or anxiety the person is experiencing while encouraging sharing with supportive individuals. Once the LGBT individual has moved out of the acute crisis phase, the group might focus on ways to protect oneself from attacks and balancing fears with reasonable action. For example, if the LGBT person wants to go to a gay bar and that was where the individual was assaulted, discussing what could be done to reduce the risk of future assaults at the bar could demonstrate appropriate problem-solving skills. Peer support groups can provide some of these same supports and may also empower the LGBT person. Scapegoating of individuals can occur within these peer support groups and can be extremely detrimental; this type of group interaction not only potentially harms the scapegoat but can be harmful to the other group members as it can intensify memories of the hate crime itself.

Another factor to consider is the impact of PTSD, depression, and/or anxiety on the survivor's ability to work successfully. All of these illnesses can impede memory function, decrease concentration, decrease energy, decrease stress tolerance, impair social interaction, and impair adaptation. In addition, in PTSD, flashbacks can cause immediate impairments in functioning. Various services such as vocational rehabilitation or counseling may be important in returning the client to the workplace successfully (Cheng, 2004).

System-Wide Interventions by APRNs

APRNs are often in positions where they can affect the system in which they work and often beyond the workplace through leadership in organizations; through advocating in their own community, region, or state; or through political activities. Because nurses are trusted individuals, they can often improve the knowledge base of individuals with whom they are in contact. By taking advantage of situations in which they often find themselves, APRNs may positively influence public opinion and attitudes by talking with others about the issue of LGBT hate crimes.

Developing Agency Policies for Dealing with LGBT Hate Crimes

Within their own institution, APRNs can identify current policies in place for dealing with LGBT hate crimes. Updating policies or instituting policies if none exist can be an important starting point for changing practice within an agency. Having current policies and treatment protocols reflecting evidence-based practice is important for every healthcare agency or setting. Following policy development, training staff in the appropriate ways of treating victims of LGBT hate crimes is critical. This training can be facilitated by the APRN.

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Teaching Nursing Students, Practicing Nurses, and Other Healthcare Providers

Another important role for the APRN is teaching other providers about LGBT hate crimes and ways to assist victims. Advanced practice psychiatric nurses often have the opportunity to be preceptors for graduate nursing students or to interact with prelicensure nursing students. These encounters are important opportunities for the APRN to help these students understand the differences in LGBT hate crimes and to recognize the ways they can assist these individuals. Similarly, the APRN has ongoing contacts with other providers and can utilize interactions to help increase the knowledge base about LGBT hate crimes either informally or through structured learning experiences. A first step, however, is for each provider to assess their own level of heterosexism.

Psychiatric Nurses, Healthcare Providers, and Heterosexism

A major requirement for psychiatric nurses to be helpful is their ability to provide care without negative assessment of people, no matter their race, creed, religion, or illness. The same is true for sexual orientation and gender identity. Psychiatric nurses have been taught to be accepting of people, but in actual practice we know there is wide variation in this ability (McFarlane, 1998; Welch, Collings, & Howden-Chapman, 2000; Wells, 1997). Some of the attitudes toward people who are LGBT are deeply ingrained, possibly having been taught to individuals as part of their religious education. Other stigmatizing attitudes about sexual orientation were taught in the mental health professions until the 1970s when the American Psychiatric Association removed homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders*. Prior to the 1970s, physicians, psychologists, nurses, and other health professionals were taught that homosexuality was an illness to be treated with therapy (Herek, 2010). *Some* nurses may not have previously examined their attitudes relating to this population. If some nurses find that they cannot be accepting of this population because of strong heterosexist beliefs, it would be better to acknowledge this fact than to ignore it, and allow other nurses who are able to be accepting of the survivors to provide services whenever possible. Various reports have documented that health professionals are not exempt from contributing to victim blaming (Grant et al., 2011; NCAVP, 2011). Our professional responsibility to our clients requires that we refrain from contributing to their distress. Just as the psychiatric nurse must help a heterosexual female rape victim deal with the self-doubts engendered by others' victim blaming, the survivors of LGBT hate crimes may need help to deal with the self-doubts raised by the many others who blame the victims in these situations. As previously noted, it is quite common for victim blaming to occur in healthcare settings and by law enforcement personnel who may also be perpetrators (Grant et al., 2011; NCAVP, 2011). Gay hate crime survivors are most likely to be blamed for the sexual assault by males than by women (Davies, Pollard, & Archer, 2006).

Discussion

The literature demonstrates that hate crimes related to sexual orientation and gender identity continue to be a major problem in this country. Significant members of the LGBT community have experienced at least one episode during their lifetimes. There are certain unique aspects to sexual orientation and gender identity-related hate crimes, including the degree of violence involved, the excuse that raping someone can be therapeutic in helping the person change orientation, and the involvement of relatives in the hate crimes as perpetrators. Because LGBT hate crime data have not been consistently collected and have been underreported, studies on the most effective treatments for this experience are lacking in the literature. Future research needs to test out what treatments would be most effective and what services should be available to assist the survivors.

Implications for Nursing Practice

Psychiatric nurses are in a prime position to help the survivors of LGBT hate crimes. We are found in many settings where the survivors may seek health care. Advanced practice psychiatric nurses may see survivors of LGBT hate crimes in emergency departments and be able to deal with the potential psychological consequences. This may include referrals to community resources, such as a victim's advocate in the judicial system, rape crisis centers, or to LGBT community services if the survivor of the LGBT hate crime is "out." It is critical to ascertain if the survivor is "out" to the public before making referrals that would accidentally "out" the survivor. Other settings where psychiatric nurses may encounter the survivors of hate crimes include critical care units if the physical injuries are severe; outpatient medical, surgical, and orthopedic services; and/or mental health services. Nurses working in high schools and colleges may see the survivors that come in for health services following a hate crime and need to investigate these situations with care.

The care psychiatric nurses provide will depend upon their role and education. All nurses can provide crisis intervention and advocate for these individuals. Advanced practice psychiatric nurses can provide various forms of interventions, including CBT and other forms of therapy, support empowerment of the patient, and even prescribe appropriate psychoactive medications. However, in order to provide effective treatments, nurses must assess their own levels of heterosexism as this would interfere with their effectiveness in treating the client.

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Conclusion

Hate crimes related to sexual orientation and/ or gender identity affect a significant percentage of individuals in the United States and in other countries. Hate crimes against individuals in the LGBT population harm the entire LGBT community, whether intentional or circumstantial. Many perpetrators commit hate crimes in the name of their religious beliefs but a major underlying factor is the fear of people who are different. Many interventions that will be helpful for survivors of LGBT-related hate crimes are well known to psychiatric nurses, including crisis intervention techniques; specific therapies for PTSD, depression, and anxiety disorders; psychopharmacological treatments; and empowerment strategies. In order to be effective, the advance practice psychiatric nurse must do a thorough assessment of the needs and wishes of the client, including their families of choice, status related to being "out," their psychosocial coping skills and deficits, safety and meaning of the incident, and their history of victimization. The body of evidence to support best practices for treatment for the survivor of LGBT hate crimes is not well developed and has been primarily extrapolated from research on other groups. Further research on interventions for this population is imperative.

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